STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634560	A. BUILDING _____ B. WING _____	4/6/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BLOOMFIELD HILLS	2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS SKLD Bloomfield Hills was surveyed for an Abbreviated survey on 4/6/22. Intakes: MI00127279, MI00127433, MI00127041, MI00127193 and MI00127308. Census= 141.	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or	F0550	Element 1 Resident #906 and #902 both still reside in facility. A room change was initiated for resident #902 per his request on or before 4/6/2022. Resident #902 care plan was updated accordingly Resident #906 was assessed by SW on 4/6/2022. Resident #906 care plan was updated accordingly. The thorough investigation was completed and provided to State of Mi on 4/4/2022. Reportable incident was closed out by State of MI on 4/12/2022. Both resident #902 and #906 have been reassessed by SW on or before 4/21/2022 regarding their psychosocial wellbeing. No further concerns have been reported at this time. Element 2 Residents with behaviors in house have the potential to be affected. The facility IDT team reviewed residents with behaviors to ensure all behaviors are care planed and being managed effectively in house. Further, a resident council meeting was held on 4/25/22 to discuss the facility grievance policy and procedures in detail. The Administrator will provide oversight of the grievance program and partner with the facility Director of Nursing to review the 24-hour report daily in clinical meeting M-F to learn of any concerns and hold Behavior Care	4/27/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/29/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00127279. Based on observation, interview and record review the facility failed to ensure the right to privacy and dignity for (R906) and ensure follow up on the request for (R902) to exercise their right to have a room change for two of four residents reviewed for dignity. Findings include: R902 Review of the clinical record revealed R902 was admitted into the facility on 7/17/21 with a readmission date of 11/20/21 with diagnosis that included: idiopathic aseptic necrosis of left femur and bipolar disorder. A Minimum Data Set (MDS) assessment dated 1/21/22 documented a Brief Interview for Mental Status score of 15 (indicating intact cognition) and required minimal staff assistance for all Activities of Daily Living (ADLs). During an interview on 4/4/22 at 9:42 AM, R902 stated in part " ... (R906- roommate to R902) plays with himself in front of everybody all of the time ... I was sitting by the dining room and saw (R906) playing with himself ..." The interview was concluded at that time and resumed at 12:19 PM. R902 stated in part, " ... I talked to (Social Worker (SW) "D") ... It's a huge problem about him masturbating everywhere ... (SW "D") totally blew that over and never followed up. (SW "D") said she will move me into another room and I'm still here ... I feel bad for him. He doesn't understand what he is doing ..." R902 denied		meetings weekly with IDT. Element 3 The facility staff were educated on 4/22/22 of the importance of honoring resident rights and addressing any concerns noted in a timely matter with ensuring effective follow- up to concern. This includes ensuring the residents right to privacy and dignity and following up on a request of the residents have a room change. Element 4 The Administrator and/or designee will conduct random audits on 5 residents weekly x4 weeks and then monthly 3 months or until substantial compliance has been maintained to ensure that resident right to privacy and dignity are honored and residents requests are followed up in a timely manner. The findings will be submitted to the QAPI Committee for further direction. The Administrator is responsible for achieving substantial compliance and maintaining substantial compliance Element 5 Date of Compliance: 4/27/2022	

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seeing R906's genitals, however stated R906's hands are frequently down in their genital area.

R906

Review of the clinical record revealed R906 was admitted into the facility on 11/23/20 with diagnosis that included: dementia and difficulty walking. A MDS assessment dated 3/2/22 documented a BIMS score of 10 (indicating moderately impaired cognition) and required staff assistance for all ADLs.

On 4/4/22 at 11:43 AM, R906 was observed in bed lying on their back. When asked how they were doing resident stated "good", then repeatedly stated good for every question asked. The remaining questions not answered appropriately, the interview was concluded.

On 4/4/22 at 2:32 PM, an attempt to interview SW "D" (currently no longer employed at the facility) was made via telephone. A message was left for SW "D" to return the call. A return call was not received by the end of survey.

On 4/4/22 at approximately 2:50 PM, an interview was conducted with Certified Nursing Assistant (CNA) "E". When asked about R906's self-pleasuring acts, CNA "E" stated they were aware of the resident touching themselves and stated "(R906) does it all of the time ..." CNA "E" stated staff would normally bring (R906) to their room or tell (R906) to stop (pleasuring themselves). When asked about it being (R906) right to pleasure themselves if they wanted to, CNA "E" acknowledged that it was R906's right and that normally staff will escort the resident to their room. CNA "E" stated in part, " ... All the staff are aware (of R906's pleasuring acts) ..."

On 4/4/22 at 3:19 PM, CNA "G" was interviewed

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	and when asked stated in part " ... (R906) does it (self-pleasuring) wherever, dining room and hallways ... We normally get him to stop or take him to his room. It's kind of an all-day thing ..." When asked if other residents informed them of their concerns regarding R906 pleasuring acts, CNA "G" stated in part, " ... Yes, his roommate (R902) ... They (other residents) pick on him (R906) because his mental status is not the same as theirs. A lot of other residents yell at him (R906) and gang up on him ... they will say "don't even look at me you pervert" ... They are mean to him. I honestly don't think that he (R906) understands what he is doing (pleasuring acts) ... Now (R906) barks like a dog because (R902) calls him "Fito" ... I let the (Corporate Director Of Nursing- CDON "A") know and I asked was there an order to get his (R902's) room switched ... (R902) is calling him (R906) "Fito" and making him bark and I said that wasn't fair. The (CDON "A") told (SW "D"). The room was never changed ... I have no idea why administration haven't done anything about it yet ..." On 4/4/22 at 3:28 PM, Social Worker Technician (SWT) "H" was interviewed and asked about R's 902 and 906 and stated (SW "D") followed up with these two residents and SW "D" is no longer employed with the facility. SWT "H" did recall SW "D" following up on R902 supposedly making R906 bark like a dog but was unsure of the details and outcome. When asked why the facility did not accommodate the request of R902 to have a room change, SWT "H" stated they were unaware of any follow up to change the resident's room. When asked why a care plan was not implemented for R906's self-pleasuring acts, SWT "H" stated they were unaware of R906's self-pleasuring acts. On 4/4/22 at 3:48 PM, the Administrator and DON was interviewed and asked about the alleged incidents between roommates (R's 902 &			

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	906), why there was no follow up regarding a room change requested by R902 and incident reported by CNA "G" and denied having knowledge of any incidents. When asked about R906's self-pleasuring acts, both denied any knowledge of it. On 4/6/22 at 8:37 AM, CDON "A" was interviewed and asked about the reported incident regarding R's 902 and 906 and why there was no follow-up into the incident. CDON "A" stated they were never informed by staff of any incident with R's 902 and 906. CDON "A" stated they overheard staff talking about (R902) having behaviors and they asked SW "D" to follow up on it. CDON "A" was also asked about R906 self-pleasuring acts and denied having knowledge of it. Review of a facility policy titled "Resident Rights and Quality of Life" dated 7/11/18 documented in part, " ... It is the policy of the facility that all residents have the right to a dignified existence ... To protect and promote the rights of each resident ..."			
F0585 SS= D	Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility	F0585	Element 1 Resident #905 no longer resides in facility. Resident #904 still resides here in the facility. The grievance reported on behalf of Residents #904 Incident/Accident from 2/5/2022 was reviewed by IDT. care plan was revised and updated on or before 4/21/2022 to ensure care plan reflects meaningful interventions related to the identified root cause to incident. Resident #904 was also assessed by a licensed nurse on or before 4/21/2022 in regard to Cath care. No signs/symptoms of distress or discomfort noted. Resident Care Plans were reviewed and updated accordingly. Facility SW conducted a follow up call with resident	4/27/2022

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	must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential		guardian on 4/20/2022 in regard to initial grievance placed in to facility. Guardian noted the positive changes to facility and did not have any further concerns related to #904 care at this time. Facility continues to monitor. Element 2 All Residents in house have the potential to be affected. The Administrator has completed an audit of grievances received dated back to 4/6 to current to ensure compliance with grievance policy. A Resident council meeting was held on 4/25/22 with residents to learn of any additional grievances and residents were educated on the facility grievance process and procedure. All grievances have been received with evidence of follow thru attached to grievance form. The Administrator will provide oversight of the grievance program and partner with the facility Director of Nursing to review the 24-hour report daily in clinical meeting M-F to learn of any concerns and hold Behavior Care meetings weekly with IDT. The process for the initiation of grievances, notification and follow up has been reviewed and changed, to include, but not limited to: • When a grievance if filled out by an employee, allegations of abuse, neglect, per our policy will be notified immediately to the Abuse Coordinator, this contact information is located throughout the facility • The grievance will be placed in the Administrators mailbox (accessible 24h a day) as the first point of contact • The Administrator will ensure that the appropriate discipline is given the grievance for timely investigation and follow up with proof of this attached to the grievance form • The Administrator will follow up with each grievance to ensure that all grievances are investigated and followed up in a timely manner.	

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	violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00127193 & MI00127308. Based on interview and record review the facility failed to implement their grievance policy and		Element 3 The facility staff were educated on 4/22/22 of the importance of ensuring grievances are brought forth and are addressed, investigated, follow-up, and resolved all within a timely fashion. The staff were also reeducated on the new grievance process which is as follows: Administrator changed the Grievance form from white to a neon green so that there is a sense of urgency around addressing needs on form. Once form is filled out by complainant, form is brought to the administrator who is the Greivance Coordinator who in turn with assign it to appropriate discipline to complete. The appropriate discipline will complete form and provide evidence as an indicator the all areas have been addressed. Element 4 The Administrator and/or designee will conduct weekly audits 5 grievance forms received weekly x 4 weeks and then monthly x3 months or until substantial compliance has been maintained to ensure that the facility implements their grievance policy and address, investigate, follow up, and resolve concerns reported to the facility. The findings will be submitted to the QAPI Committee for further direction. The Administrator is responsible for achieving substantial compliance and maintaining substantial compliance Element 5 Date of Compliance: 4/27/2022	

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	address, investigate, follow up, and resolve concerns reported to the facility staff for two (R's 904 and 905) of three residents reviewed for grievances. Findings include: Review of a complaint submitted to the State Agency (SA) documented in part, " ... Has reported concerns directly to staff at facility during family meetings, however ... does not feel concerns have been taken seriously ..." Review of grievances for R's 904 and 905 revealed the following: R904 Review of a grievance report dated 2/10/22 at 1 PM, documented in part " ... Describe Grievance ... Fall on 2/5/22 at 3:00 P, Guardian called at 6:30 P, Bruise on head does not understand how he fell ... Foley in prostate, urine backed up into kidneys want a phone call ... Administrator Assigned to (Corporate DON (CDON) "A" name documented) ... Investigation ... spoke with guardian ... explained intervention r/t (related to) fall and also positive chest x-ray and initiation of antibiotic therapy for diagnosis of pneumonia. Guardian pleased with conversation and intervention in place ... Resolution- Perimeter mattress to bed, which is in place ... Date complainant notified of resolution: 2/10/22, Family Satisfied: Yes ..." The grievance was signed by the Administrator as acknowledged on 2/10/22. The facility did not complete an investigation into the guardian's concern regarding how the resident fell or why/how the urinary foley balloon was found inflated in the resident's prostatic urethra. The complaint submitted by the third party documented the ongoing concern of the guardian feeling as if their concerns are not being taken seriously by the facility staff.			

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On 4/6/22 at 12:13 PM, CDON "A" was interviewed and asked about the grievance for R904 and stated they did look into it, however failed to document the investigation. When asked what the facility findings were for the reason for the fall and the urinary catheter balloon found inflated in the prostatic urethra, CDON "A" did not have a response.

Review of facility policy titled "Grievances" updated 5/2/19 documented in part, " ... It is the policy of this facility to investigate all grievances registered by, or on behalf of a resident ... Purpose ... To provide a system that allows residents, families, staff and others to bring comments of grievances and satisfaction to the attention of the Administrator which allows the team to investigate and bring resolution in a timely manner ..."

R905

Review of a grievance report dated 3/2/22, documented in part " ... Describe Grievance ... Concerns of mothers care, daughter states staff not getting her mother up to go to the bathroom at all, concerns about her wound care ... Does not like meals at all, daughter states care so bad ... Administrator Assigned to: (blank) ... Investigation (blank) ... Resolution ... requested wound nurse to call daughter to provide update of wound ... (dietician name) to call daughter regarding diet ... Complainant Notified of Resolution (blank) ..." the Administrator signed and acknowledged the form on 3/18/22.

On 4/5/22 at 4:14 PM, the Administrator was interviewed and asked about the incomplete follow up and documentation of the grievances for R's 904 and 905 and stated they did not know what the follow up was. The Administrator stated a grievance should have been completed for each

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	discipline, so that the concerns would be followed up and followed through. When asked why they signed off on the grievances if the concerns were not completely addressed, the Administrator did not offer an explanation. Further review of the facility's policy titled "Grievances" updated 5/2/19 documented in part, " ... The facility Administrator or designee in the absence of the administrator, has been designated to receive all grievances ... The Administrator or designee in the absence of the administrator, shall confer with persons involved in the incident and other relevant persons and within three to seven days of receiving the grievance shall provide a written explanation, upon request, of findings and proposed remedies to the complainant and the aggrieved party ... During the investigation the facility will put in place immediate action to prevent potential violation of resident rights ... All written grievance decisions will include ... the steps taken to investigate the grievance ... summary of pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken to be taken by the facility as a result of the grievance ... The Administrator is in charge of the oversight related to all comments of Grievances and Satisfaction ... the Administrator who will determine what actions need to be taken and who will follow up on the Grievance ... The Administrator should actively participate in the investigation and resolution but may delegate portions of the tasks to the appropriate individuals..."			
F0600 SS= D	Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not	F0600	Element 1 Resident #908 and #907 still resides in facility. The resident-to-resident altercation was reported to the state of mi on 4/4/2022. The state of mi closed out reportable on 4/11/2022.	4/27/2022

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	limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to prevent resident to resident abuse for two (R's 907 & 908) of five residents reviewed for abuse. Findings include: Review of a Facility Reported Incident (FRI) documented R907 called R908 a bit** and R907 pushed/hit R908 on the back. No injury occurred. On 4/6/22 at 9:51 AM, R907 was observed sitting in the community room sleeping in their wheelchair. R907 was easily arousable with verbal stimuli. When asked if they have ever been hit by another resident in the facility, they initially denied it then stated "some big boys are nasty, but you know boys hit girls and play games ..." resident appeared to be recalling memories from their past. Review of the clinical record revealed R907 was admitted into the facility on 12/4/18 with diagnoses that included: Alzheimer's disease and dementia. A Minimum Data Set (MDS) assessment dated 3/15/22 documented a Brief Interview for Mental Status (BIMS) score of 00 (indicating severely impaired cognition) and required staff assistance for all Activities of Daily Living (ADLs). On 4/6/22 at 9:57 AM, R908 was observed sitting		There have been no further incidents between either resident. Alleged abuse was reported immediately, the residents were immediately separated, The residents were assessed immediately for injury, Physician and family notified, and State 24-hour report submitted. residents have been reassessed by SW on or before 4/20/2022. No further concerns noted. Residents remain at baseline. Both residents are being followed by facility pysch services. Element 2 Residents in house with exhibiting behaviors have the potential to be affected. The Director of Nursing reviewed all residents in house with the potential of exhibiting violent behavior and ensure care plans reflect meaningful interventions for residents. The Director of Nursing will provide oversight of the daily clinical meeting M-F to review behaviors as well as hold Behavior Care meetings weekly with IDT. Element 3 The facility Abuse Prohibition Policy and Procedures have been reviewed by IDT and deemed appropriate. Facility staff were in serviced on 4/22/22 on the abuse policy, with emphasis on resident-to-resident abuse, and the importance of being aware of resident(s) presence on unit who have exhibiting behaviors to prevent any altercations from occurring. If any resident who does exhibit these behaviors will be immediately reported to their supervisor and addressed accordingly the appropriate intervention applied. Element 4 The administrator and/or designee will conduct random audits on 5 residents with documented behaviors weekly x4 weeks and then monthly thereafter x3 months or until substantial compliance has been maintained to ensure proper interventions are being	

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	634560	A. BUILDING _____ B. WING _____	4/6/2022

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	in their wheelchair in their room. When asked the resident denied have any issues with other residents in the facility. When specifically asked if they ever hit another resident or if a resident had ever hit them, the resident stated "No". When asked, the resident stated they can't walk but is able to transfer self and "do everything else for myself". The resident denies having any issues or concerns at the facility. Review of the clinical record revealed R908 was admitted to the facility on 2/14/18 with a readmission date of 6/3/21 and diagnoses that included vascular dementia with behaviors. A MDS assessment dated 2/11/22 documented a BIMS of 15 indicating intact cognition and required minimal assistance from staff for all ADLs. Review of R908's care plan titled "The resident has a mood problem ..." created on 3/26/19 documented in part, " ... Resident has history of yelling at confused resident that may enter room ... Resident hit confused resident ... Interventions ... When conflict arises, remove resident to a calm safe environment and allow to vent/share feelings ..." This indicated the resident had a known behavior to be verbally and physically aggressive with other residents. A "Nursing" note dated 11/24/21 at 6:50 PM, documented in part " ... Writer overheard resident, tell another resident, "Didn't I tell <sic>, not to come in my (profanity) room anymore? Next time I cath <sic> you in my room. I will beat your (profanity) ..." (Involved resident later identified as R909, another confused resident that resides in the room next to R908). A "Nursing" note dated 4/4/22 at 4:33 PM, documented in part " ... Staff witnessed resident hit resident in back and push back of wheelchair		followed for residents with behaviors to aid in the prevention of resident-to-resident abuse. The findings will be submitted to the QAPI Committee for further direction. The Administrator is responsible for achieving substantial compliance and maintaining substantial compliance	

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	hard. Residents were immediately separated and administrator informed. Other resident involved (R907) was assessed and is okay. Little to no redness noted on the upper back ..." On 4/6/22 at 12:53 PM, Central Supply Personnel (CSP) "C" (staff member that witnessed the incident of R908 hitting R907) was interviewed and asked about the incident that occurred between R's 907 and 908 on 4/4/22. CSP "C" stated in part, " ... I was walking through the door, and I see (R908) push (R907) from the back and then (R908) hit her and I immediately separated them and as I separated them (R908) was mad ... (R908) said (R907) called her a b**** and that's why (R908) hit (R907). (R908) was just having a bad day ..." CSP "C" continued to say the facility's abuse coordinator (Administrator) had just walked on the unit and was informed of the incident. The Administrator was not available during this investigation for an interview. Review of a facility policy titled "Abuse and Neglect" revised 6/17/19, documented in part " ... It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse ... or mistreatment ... Abuse the willful infliction of injury ... Physical abuse includes but not limited to infliction of injury that occur other than by accidental means ... hitting, slapping ..."			
F0656 SS= D	Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a	F0656	Element #1 Resident #906 still resides in facility. Residents comprehensive care plan was assessed by a Licensed Nurse on or before 4/20/2020 and appropriate interventions for residents that will continue to honor his rights. SW reassessed resident on 4/20/2022 and no additional concerns were noted at this time.	4/27/2022

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	resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00127279. Based on interview and record review the facility failed to develop a comprehensive person-centered behavior care plan for one (R906) of		Resident continues to be followed by facility psych services. Element 2 Residents in house with exhibiting behaviors have the potential to be affected. The Director of Nursing reviewed all residents in house with the potential of exhibiting behaviors to ensure facility is honoring resident rights for privacy without judgment and criticism from peers. Care plans were updated to reflect the same. The Director of Nursing will provide oversight of the daily clinical meeting M-F to review behaviors as well as hold Behavior Care meetings weekly with IDT. Element 3 The facility's Care Planning policy and procedure was reviewed by IDT on 4/22/22 and deemed appropriate. The facility IDT were re-educated on 4/22/2022 on ensuring comprehensive care plans are individualized to each resident. Element 4 The Director of Nursing or designee will audit 5 residents records weekly x4 weeks and then monthly thereafter x3 months or until substantial compliance has been maintained to ensure the that resident comprehensive care plans are person centered/individualized for that specific resident. Any issues identified during the audit will be addressed immediately and reported for further recommendation by the monthly Quality Assurance Committee. The Director of Nursing is responsible for maintaining and sustaining compliance.	

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four residents reviewed for behaviors. Findings include:

Review of the clinical record revealed R906 was admitted into the facility on 11/23/20 with diagnosis that included: dementia and difficulty walking. A MDS assessment dated 3/2/22 documented a BIMS score of 10 (indicating moderately impaired cognition) and required staff assistance for all ADLs.

On 4/4/22 at 11:43 AM, R906 was observed in bed lying on their back. When asked how they were doing resident stated "good", then repeatedly stated good for every question asked. Questions not answered appropriately, the interview was concluded.

On 4/4/22 at approximately 2:50 PM, an interview was conducted with Certified Nursing Assistant (CNA) "E". When asked about R906's self-pleasuring acts, CNA "E" stated they were aware of the resident touching themselves and stated "(R906) does it all of the time ..." CNA "E" stated staff would normally bring (R906) to their room or tell (R906) to stop (pleasuring themselves). When asked about it being (R906) right to pleasure themselves if they wanted to, CNA "E" acknowledged that it was R906's right and that normally staff will escort the resident to their room. CNA "E" stated in part, " ... All the staff are aware (of R906's pleasuring acts) ..."

On 4/4/22 at 3:02 PM, Licensed Practical Nurse (LPN) "F" was interviewed and asked about R906's self-pleasuring acts and LPN "F" stated in part, " ... I don't want to say that he is sitting there masturbating but it does look like that is what he is doing but immediately when he does it, we take him to his room ... His hands is just down there ... Residents they will say something like "what are you doing" at that time we just go and get him

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	and take him into his room ..." On 4/4/22 at 3:19 PM, CNA "G" was interviewed and when asked stated in part " ... (R906) does it (self-pleasuring) wherever, dining room and hallways ... We normally get him to stop or take him to his room. It's kind of an all-day thing ... They (other residents) pick on him because his mental status is not the same as theirs. A lot of other residents yell at him and gang up on him ... they will say "don't even look at me you pervert" ... They are mean to him. I honestly don't think that he (R906) understands what he is doing (pleasuring acts) ..." Review of R906's care plans revealed no implementation of a self-pleasuring/masturbation care plan. On 4/4/22 at 3:48 PM, the Administrator and DON was interviewed and asked about R906 care plan for self-pleasuring acts, having the right for privacy without judgement and criticisms from peers, both the Administrator and DON stated they had no knowledge of R906's self-pleasuring acts.			
F0689 SS= D	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00127193.	F0689	Element 1 Resident #904 still resides in facility. It was identified that #904 fall on 2/5/2022 did not reflect a root cause analysis. The incident for 2/5/2022 was reviewed carefully by licensed nurse on or before 4/20/2022 and care plan was updated accordingly. Facility SW conducted a follow up call with resident guardian on 4/20/2022 in regard to initial grievance placed in to facility. Guardian noted the positive changes to facility and did not have any further concerns related to #904 care at this time. Facility continues to monitor. Element 2 Residents in house who are at risk for	4/27/2022

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	Based on observation, interview and record review the facility failed to complete a root cause analysis of a fall for one (R904) of two residents reviewed for falls. Findings include: Review of a complaint submitted to the State Agency documented concerns of a fall for a patient with "neurological deficits and a flap on his head from recent plastic surgery". On 4/5/22 at 11:30 AM, R904 was observed lying in bed on their back with their eyes closed. The resident was not awakened by verbal prompts. Oxygen was administered via nasal cannula and enteral feeding was administered via gastrostomy tube. Review of the medical record revealed R904 was admitted to the facility on 6/28/19 with a readmission date of 3/22/22 and diagnoses that included: chronic respiratory failure with hypoxia, paraplegia, chronic embolism and thrombosis and history of malignant neoplasm of brain. A Minimum Data Set (MDS) assessment dated 1/12/22 documented "severely impaired" cognition skills for daily decision making, required two staff for bed mobility and staff assistance for all Activities of Daily Living (ADLs). Review of a "Grievance and Satisfaction Form" dated 2/10/22 at 1 PM, documented in part " ... Describe Grievance ... Fall on 2/5/22 at 3:00 P, Guardian called at 6:30 P, bruise on head. Does not understand how he fell ... Investigation ... explained intervention r/t (related to) fall ... perimeter mattress to bed, which is in place ..." Completed by the Corporate Director of Nursing (CDON) "A". Review of a "Nursing" note dated 2/5/22 at 7:10 PM, documented in part " ... Upon CENA (aide)		falls/accidents are considered like residents. An audit was completed on residents who had a fall in the past 60 days to ensure that a root cause analysis was completed and appropriate. The Director of Nursing educated staff of the importance of completing incident and accident report effectively and proper follow through to prevent repeat falls from occurring. The Director of Nursing will provide oversight during daily clinical meetings M-F where falls will be discussed in detail and interventions put in place. Element 3 The facility Best Practice Risk Management Program was reviewed and deemed appropriate. Licensed nursing staff were re-educated by the Director of Nursing on 4/22/22 on the Best Practice Risk Management Program with emphasis on completion of root cause analysis of incident/accidents. Element 4 The Director of Nursing/designee will audit 5 residents identified for falls weekly x4 weeks and then monthly x3 months or until substantial compliance has been maintained to ensure the root cause analysis and appropriate interventions are in place s/p incidents/accidents. Any issues identified during the audit will be addressed immediately and reported for further recommendation by QAPI committee. Element 5 Date of Compliance: 4/27/2022	

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	entering resident's room, he observed resident on the floor, CENA came to get writer, writer also observed resident on the floor, writer obtained V/S (vital signs) and assessed resident ... observed no injuries ... MD (Medical Doctor) ... ordered neuro checks and to monitor resident closely for any changes ... Fall mats placed on both sides of the bed ..." Review of a facility incident report dated 2/5/22 at 6:56 PM, documented in part " ... Incident Description: Resident was observed on the floor by CENA, who then came to get writer ... Patient Unable to give Description ... Writer assessed resident, obtained V/S (Vital Signs), called MD (Medical Doctor) and placed fall mats on both sides of the bed ... Mobility: Bedridden ... Predisposing Environmental, Physiological and Situation Factors (all blank) ... Resident fell out of bed ... No witnesses found ..." Review of the clinical record revealed no Interdisciplinary meeting conducted or investigation to determine the root cause of R904's fall. On 4/6/22 at 12:13 PM, CDON "A" was interviewed and asked if R904 could move themselves out of bed and CDON "A" stated in part " ... He has some movement but probably not enough to fall out of bed ..." When asked about the investigation to find the root cause of a resident who is unable to move being found on the floor out of bed, CDON "A" stated they looked into it, however, could not provide documentation of an investigation or an IDT meeting to discuss the root cause analysis of R904's fall. When asked what the facility identified as the cause for R904's fall (being that they are unable to move) and CDON "A" did not provide a response.			

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	Review of a facility policy dated 7/11/18, documented in part " ... Evaluate for cause of fall ..."			
F0690 SS= D	Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00127193.	F0690	Element 1 Resident #904 still resides in the facility. Resident #904 was reassessed by licensed nurse on or before 4/21/2022. Resident has an order for indwelling catheters in place for the care of an indwelling catheter. Nurse E was provided immediate education on or before 4/21/2022 regarding the policy for catheter care and infection control practices. Element 2 Residents in house with indwelling catheters have the potential to be affected. Facility conducted an audit of all residents in house with indwelling catheters to ensure that orders for catheter care are in place. The Director of Nursing will provide oversight during daily clinical meeting M-F and will review all new admissions/readmissions charts with IDT upon admission and residents with new orders for indwelling catheters to ensure proper order and interventions for resident with indwelling catheter care is in place. Care plans will be revised and updated to reflect such findings. Element 3 The Facility policy on catheter care was reviewed by IDT and deemed appropriate. Facility Licensed nurses and CENAS were in service on 4/22/2022 on catheter care policy and orders for catheter care to ensure that residents with indwelling catheter have catheter care orders implemented in a timely manner. Element 4 The DON/designee will conduct random audits on 5 residents weekly x4 then monthly thereafter times 3 months or until substantial	4/27/2022

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	Based on observation, interview and record review the facility failed to timely implement catheter care orders for one (R904) with an indwelling urinary catheter of one resident reviewed for catheter care. Findings include: Review of a complaint submitted to the State Agency (SA) documented in part, " ... Patient has been experiencing frequent UTIs (Urinary Tract Infections) that have led to repeated hospital admissions for treatment. It is believed these frequent UTIs are due to neglectful care on behalf of the facility ..." On 4/5/22 at 11:30 AM, an observation of R904 lying in bed with oxygen being administered via nasal cannula and enteral feeding being administered via gastrostomy tube was made. A urinary foley bag was observed hooked to the lower right side of the bed. The foley bag was laying partially on a visibly dirty grey mat placed on the right side of the bed. Clear yellow urine was visible in the catheter tubing. Review of the medical record revealed R904 was admitted to the facility on 6/28/19 with a readmission date of 3/22/22 and diagnoses that included: chronic respiratory failure with hypoxia, paraplegia, history of malignant neoplasm of brain and history of UTIs. A Minimum Data Set (MDS) assessment dated 1/12/22 documented "severely impaired" cognition skills for daily decision making and had the presence of an indwelling urinary catheter (Reviewed from all MDS assessments completed from December 2021 to current). Review of the clinical record revealed multiple hospitalizations since February 2021. The following hospitalizations were found to be associated with urinary concerns:		compliance is attained and maintained to ensure the licensed nurses and CNAs are ensuring that residents with indwelling catheters tubing is kept off the floor and that residents with indwelling catheters have catheter care orders in place. The results of these audits will be presented to the QAA committee for review and consideration of further corrective actions monthly. Element 5 Date of compliance 4/27/2022	

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	5/11/21- Diagnosis- Sepsis, Urinary Tract Infection and pyelonephritis (Inflammation of the kidney due to a bacterial infection). 1/26/22- Diagnosis- Sepsis, Shortness of breath. Urinary catheter balloon found inflated in the prostatic urethra (this indicated the catheter was not inserted correctly and the catheter balloon was prematurely inflated). 3/13/22- Diagnosis- Urinary Tract Infection Review of a hospital discharge "After Visit Summary" dated 12/30/21 at 12:28 PM, documented the resident being discharged to the facility with a urinary catheter inserted. Review of the medical record failed to reveal an order for catheter care until 2/4/22. On 4/5/22 at 12:00 PM, the DON was asked how the facility was ensuring catheter care was being completed for the urinary catheter prior to the implementation of the 2/4/22 urinary catheter care order. The DON stated they would look into it and follow up. At 1:03 PM, the DON confirmed the catheter care orders were not created until 2/4/22 (at this time the DON provided an audit report that revealed catheter care orders were not implemented until 2/4/22) and further stated an order should have been created in December when the resident was readmitted to the facility. The DON was then asked if R904's urinary catheter bag should be laying on the grey mat placed on the side of the bed and the DON stated that the bag should not be on the mat. The DON did not provide any additional documentation or explanation before the end of survey. Review of a facility policy titled "Catheter, Indwelling Care of" dated 7/11/18 documented in part, " ... It is the policy of this facility to improve			

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	634560	A. BUILDING _____ B. WING _____	4/6/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BLOOMFIELD HILLS	2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304

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	hygiene/reduce infection by ensuring that catheter care is done at least daily ..."			
F0692 SS= D	Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: This citation pertains to intake: MI00127308. Based on interview and record review the facility failed to accurately assess a resident's nutritional status on admission by not acknowledging a medical diagnosis of diverticulitis and implement a diet specifically for a resident with diverticulitis for one (R905) of two residents reviewed for nutrition. Findings include: Review of a complaint submitted to the State Agency (SA) revealed, "...She is not supposed to have corn but was fed corn anyway. The meals	F0692	Element 1 Resident #905 no longer resides in facility Element 2 Residents residing in the facility have the potential to be affected. The root cause identified was to ensure that upon residents admissions, residents medical diagnosis and nutrition plan properly align with each other. It has been identified that the facility has inhouse 3 residents who have a diagnosis of diverticulitis. All 3 residents were reviewed by Register dietician on or before 4/20/2022. Food preferences in relation to diagnosis were discussed with residents. Care plan and meal tickets have been updated accordingly to reflect resident needs. During facility daily clinical meetings, new admissions/readmissions medical records will be reviewed closely by IDT to ensure there are nutrition care plan are appropriate to current resident medical needs. Element 3 The facility policy on Nutritional services was reviewed by IDT and deemed appropriate. Facility licensed nurses were educated on 4/22/22 on reviewing medical charts upon admissions to ensure nutrition plans align with resident medical needs. The RDO was re-in serviced on the assessment of residents nutritional status upon admission to ensure that a residents medical diagnosis is taken into account if needed for dietary preferences/needs. Element 4 The RDO and/or designee will audit 5 resident admissions weekly x4 weeks and then monthly thereafter x3 months or until substantial compliance has been maintained	4/27/2022

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	were not given pursuant to each patient's care..." Review of the clinical record revealed R905 was admitted into the facility on 1/19/22 with a primary diagnosis of diverticulitis of intestine. A Minimum Data Set (MDS) dated 1/22/22 documented a Brief Interview for Mental Status (BIMS) score of 13 indicating intact cognition and requiring staff assistance for all Activities of Daily Living (ADLs). Review of an admission "Dietary Evaluation" dated 1/20/22 failed to document that R905 had an admitting diagnosis of diverticulitis, and therefore did not recommend a therapeutic diet. Further review of the evaluation revealed, "...Pt. (patient) is currently on CHO (Carbohydrate) Controlled diet ... Diet as ordered ... Recommendations ... NA ..." Review of a "Physician Services" notes dated 2/3/22, 2/9/22, and 2/17/22 all documented in part " ... Continue diet consistent with diverticulitis ..." However further review of the medical chart failed to reveal a physician order for a diet consistent with diverticulitis. Review of R905's nutrition care plan revealed no documentation of a diagnosis of diverticulitis or interventions pertaining to the diagnosis. On 4/5/22 at 3:16 PM, Registered Dietician (RD) "B" was interviewed and asked what foods a person should avoid with a diagnosis of Diverticulitis. RD "B" replied in part " Generally, nuts, seeds, skin, spicy foods. It's really an individual basis. They should have more bland foods. When asked why R905's admission dietary evaluation and diet did not acknowledge their diagnosis of diverticulitis and served foods not consistent with diverticulitis, RD "B" begin to review their assessment in the computer and		to ensure that an appropriate diet is implemented for a resident with a medical diagnosis of Diverticulitis if applicable. The results of these audits will be presented to the QAA committee for review and consideration of further corrective actions monthly. The Director of Nursing will be responsible for maintaining and sustaining compliance. Element 5 Date of Compliance: 4/27/2022	

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	stated "I didn't note any restrictions ..." No further explanation or documentation was provided by the end of survey.			